TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Barry Simpson, D.C.

**Respondent Name**
New Hampshire Insurance Company

**MFDR Tracking Number**
M4-15-3284-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
June 5, 2015

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "THE CURRENT RULES ALLOW REIMBURSEMENT"

**Amount in Dispute:** $84.12

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The carrier has issued payment per the fee schedule and Rule 134.204(i)(1)(c)."

**Response Submitted by:** AIG

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 26, 2014 | Range of Motion Testing (95851) | $84.12 | $84.12 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursement of Division-specific services.
3. 28 Texas Administrative Code §134.203 sets out the guidelines for billing and reimbursement of professional medical services.
4. 22 Texas Administrative Code §78.13 defines the scope of practice for chiropractors.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Workers Compensation State Fee Schedule Adjustment.
   - A procedure has been billed which is out of the scope of practice for this provider.

**Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier denied disputed services stating, "A procedure has been billed which is out of the scope of practice for this provider." The disputed services involve CPT Code 95851, which is defined as "Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)." 22 Texas Administrative Code §78.13 (c)(1) states, in relevant part, "In the practice of Chiropractic, licensees of this board provide necessary examination and evaluation services to: (A) Determine the bio-mechanical condition of the spine and musculoskeletal system of the human body including, but not limited to, the following: … (iii) the existence of the structural pathology, functional pathology or other abnormality of the system…"

   Review of the submitted information finds that the provider, as a chiropractor was within the scope of his practice to perform a range of motion evaluation. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. Submitted documentation finds that the disputed services are billed in conjunction with an examination to determine extent of injury. 28 Texas Administrative Code §134.204 states, in relevant part, "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations … Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

   Disputed CPT Code is therefore subject to fee guidelines found in 28 Texas Administrative Code §134.203, which state in relevant part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules… (c) … (2) … Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The division conversion factor for 2014 is $55.75.

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.16 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 0.16224. The practice expense (PE) RVU of 0.33 multiplied by the PE GPCI of 1.004 is 0.33132. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.939 is 0.00939. The sum of 0.50295 is multiplied by the Division conversion factor of $55.75 for a MAR of $28.04 at 3 units is $84.12.

3. The total MAR for the disputed services is $84.12. The insurance carrier paid $0.00. Therefore, an additional reimbursement of $84.12 is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $84.12.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $84.12 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | Laurie Garnes | July 13, 2015 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.